TRICARE OTHER HEALTH INSURANCE (OHI) COVERAGE QUESTIONNAIRE

Providers: Please provide this form to eligible beneficiaries

1 – General Information

TRICARE Sponsor Name: _____ TRICARE Sponsor SSN: _____

Do you or any of your family members currently have Other Health Insurance (OHI) coverage? ☐ Yes ☐ No

Have you or any of your family members had Other Health Insurance (OHI) coverage in the past 12 months? ☐ Yes ☐ No

If you answered yes to question 1 or 2 above, please complete the remainder of the form (duplicate form for multiple policies). Regardless of your answers above, please read and sign the form at the bottom and submit the form to the address or fax number below.

2 – Current OHI Status – Complete only if you or any of your family members currently have OHI.

Policy Holder Name: _____ Policy Number: _____ Group/Plan Number: _____

Name of Carrier: _____ Effective Date: _____ Expiration Date: _____

Carrier Address and Phone No: _____

Please indicate the type of coverage: ☐HMO/PPO ☐Medicare ☐Single ☐Group ☐Supplemental ☐Private ☐Medic aid/MediCal ☐Other: _____

Does this coverage include pharmacy benefits? ☐Yes ☐No Does this coverage provide any other benefit riders? ☐Yes ☐No

If Yes, please indicate which one(s): _____

Name of Covered Member:	**Member ID:**	**Date of Birth:**	**Sex:**	**Effective Date** (If different)	**Expiration Date** (if different)

3 – Prior OHI Status – Complete only if you or any of your family members have had OHI within the last 12 months, but do not have coverage now.

Policy Holder Name: _____ Policy Number: _____ Group/Plan Number: _____

Name of Carrier: _____ Effective Date: _____ Expiration Date: _____

Carrier Address and Phone No: _____

Please indicate the type of coverage: ☐HMO/PPO ☐Medicare ☐Single ☐Group ☐Supplemental ☐Private ☐Medic aid/MediCal ☐Other: _____

Does this coverage include pharmacy benefits? ☐Yes ☐No Does this coverage provide any other benefit riders? ☐Yes ☐No

If Yes, please indicate which one(s): _____

Name of Covered Member:	**Member ID:**	**Date of Birth:**	**Sex:**	**Effective Date** (If different)	**Expiration Date** (if different)

The statements made above are true and correct to the best of my knowledge. I understand that federal laws [8 U.S.C. and 100] provide for criminal penalties for submitting or making false, fictitious or fraudulent statements or claims in any matter within jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from Uniformed Services legal offices, public libraries and many Health Benefit Advisors.

_____ Your Signature

_____ Relationship to TRICARE Sponsor

_____ Date

Please Note: Incomplete forms may result in a claims payment delay.

Mail Form to:
Humana Military Healthcare Services
P.O. Box 740061, Louisville, KY 40201-7461
(502) 580-1860 Fax